COMMUNITY HEALTH FIRST

Opening Doors to Care Across Victoria

Impact Statement 2026



Community health opens the door to care for more than 730,000 Victorians. Close to home, in their language, delivered by people who know their community.

OUR PARTNERS

ACCESS Health & Community

Ballarat Community HEALTH

bch Bellarine Community Health

Bendigo Community Health Services

BHN Better Health Network

cohealth care for all

DPV Health®

Each

gateway health People living well

Gippsland Lakes Complete Health

Grampians Community Health

healthAbility

Holstep Health Community care. For life.

ipc Health

north richmond community health Wulempuri - Kertheba

Latrobe Community Health Service

NOCH

omnia Community Health

PRIMARY CARE CONNECT

SCHS Sunraysia Community Health Services

your COMMUNITY HEALTH

MESSAGE FROM OUR CEOS

When mainstream healthcare becomes harder to reach, community health is there to open its doors to those who need support.

For many Victorians, accessing care felt harder this year. As the cost of housing, groceries and petrol climbed, so did the cost of seeing a GP, psychologist or physio. For many people, care and services that once felt accessible suddenly felt out of reach, and more people turned to community health.

That is what community health is here for. For more than 50 years, we have been the safety net in Victoria's health system. We are the place people can turn to when other doors close, whoever they are, wherever they live and whatever they can afford. **This year our 21 organisations supported 736,018 people across 254 locations** — from public housing towers in North Richmond to primary schools in Gippsland. We reached people where they are: in their language, in their neighbourhood, and often helped with more than one concern, with **over 1 in 4 clients accessing multiple services** through their local organisations.

For many people it is the only support they can fall back on. Whether it's a nurse visiting someone at home, early speech therapy for a child, rehabilitation after a stroke, or support for alcohol and drug use before crisis point, having the right care within reach can change the trajectory of someone's life.

We also secured new funding to expand a services supporting people living with chronic health conditions, supporting people to build confidence in managing their health and to stay well at home. We continued to build capacity and deepened our knowledge of client outcomes through our shared data and evaluation project, and we developed and introduced a new sector-wide evaluation framework.

None of this would be possible without our people. Thank you to the nurses, allied health professionals, doctors, counsellors, social workers, support staff and volunteers who show up for their communities every day. Your care is why people keep coming back, and it is how we build healthier and more connected communities.

Being a safety net brings its own pressures. More people are turning to community care at a time when the cost of delivering care is rising faster than the funding that supports it and without further investment waitlists will continue to grow, no matter how innovative our teams are in finding new ways to reach more people.

Community health is a vital part of the Victorian health system, and with the right investment we can keep opening our doors and providing support in our communities when people need it most for many years to come.

"It was a safety net. It was a backup. It was like, someone's got your back. It's not just us out there alone."

Dave, Bellarine Community Health Client

OUR IMPACT IN 2026

The year in numbers

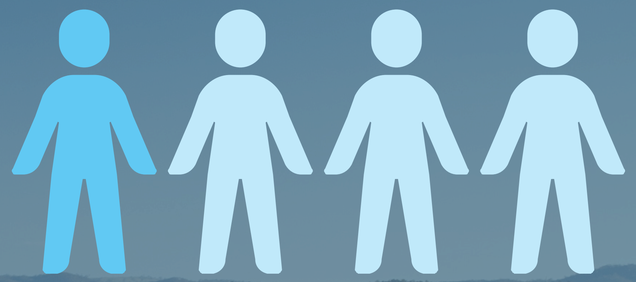
736,018
Clients

11,035
Staff

21
Organisations

OUR IMPACT IN 2026

CARE THAT WRAPS AROUND THE PERSON



1 in 4 clients accessed more than one service through community health

1 in 10 Victorians access community health services

254
Locations

"I am exceptionally grateful for the service and help I have been granted, enabling me to stay in my own home whilst keeping safe and in good health" - Community Health Client

2,248 Volunteers

1,000+ Student placements offered

"Community health is a very accepting and supportive environment with kind staff and reliable service to the community." - Community Health Client

500,000+
hours of care delivered through the **Community Health Program**

New community health initiatives

01

NEW GUIDELINES

Impact evaluation framework

The new Community Health Impact Evaluation Framework gives the sector one shared, practical way to evaluate impact: **what is measured, how evidence is read, and how findings are used for improvement, sector learning and policy.**

It assesses contribution rather than attribution, recognising that health is shaped by much more than any one service.

Organisations collect an agreed minimum common dataset during routine service delivery, including the Personal Wellbeing Index, K10 and EQ-5D-5L, and review results alongside local data, consumer feedback and context. Measures that are supported by, and matter to, our communities.

Evidence is organised around six impact domains, from health and wellbeing to equity and system insight, plus two enabling domains covering data quality and capability. Reporting is tailored to each audience, from clinicians to policymakers.

The framework aligns with the Victorian Government's Early Intervention Investment Framework and Department of Health priorities for prevention and integrated care, giving the sector a consistent evidence base for future planning and investment.



6
Impact domains

2
Enabling domains

DEVELOPED BY THE SECTOR FOR THE SECTOR

COLLECT
An agreed minimum dataset

INTERPRET
Read results alongside service data and consumer feedback

USE
Improve practice and share learning across the sector

NEW FUNDING

Care pathways for chronic disease

This year the Victorian Government announced the expansion of Care Pathways for Chronic Disease, a program pioneered by community health. It will support thousands of Victorians living with conditions like type 2 diabetes, heart disease and chronic obstructive pulmonary disease to manage their health and get care closer to home, without needing to go to hospital.

The program builds on **Health@Home Pathways**, a model first developed and tested by Each in partnership with Eastern Health. The pilot supported more than 240 people in Melbourne's eastern suburbs, most aged 70 to 89 and living with multiple chronic conditions. An independent La Trobe University evaluation found **72% of participants felt better able to manage their own health**, emergency department presentations and hospital admissions dropped significantly, and the program **saved up to $13 in healthcare costs for every $1 invested**.

The new funding takes that proven model to **12 locations across Victoria, supporting an additional 4,500 people**, so more Victorians can get coordinated chronic disease care in their community.

"Problems get sorted out before they become too big. Louise has time to come and sit on the end of the bed and explain things to me. It makes a big difference, especially if you're on your own."

John, Health@Home Client



NEW PROGRAM

A place in the shed for women

healthAbility's Community Shed identified a gap: women had fewer opportunities to access the social connection, practical skills and sense of belonging traditionally associated with Men's Shed programs.

The solution? The new Women's Shed, a structured introductory program offering a safe and welcoming space for women to try woodworking, repair projects and other hands-on activities while building social connections. It was designed as a pathway into ongoing participation in the broader Community Shed.

Every participant who has completed the program has stayed engaged and moved into the Community Shed. Women reported greater confidence, new practical skills, and a stronger sense of connection and belonging. They have formed new relationships, contributed to community projects and strengthened the Shed's inclusive culture.

"Everyone is included and made welcome," one participant said. **"It's so encouraging, even if I say I can't do it, I'm talked through the process so I can learn,"** said another. The program has shown that the strengths of the traditional shed model can be kept while opening it up to a broader range of community members.

"I never want to stop coming."

healthAbility



NEW PROGRAM

Filling a gap in peer-led harm reduction



Better Health Network has established one of Victoria's few dedicated peer-led harm reduction programs for people who use performance and image enhancing drugs (PIEDs).

People who use PIEDs often fall outside traditional health and alcohol and other drug services. The PIEDs Peer Harm Reduction Program addresses this gap with low-barrier, non-judgemental support delivered by peer workers.

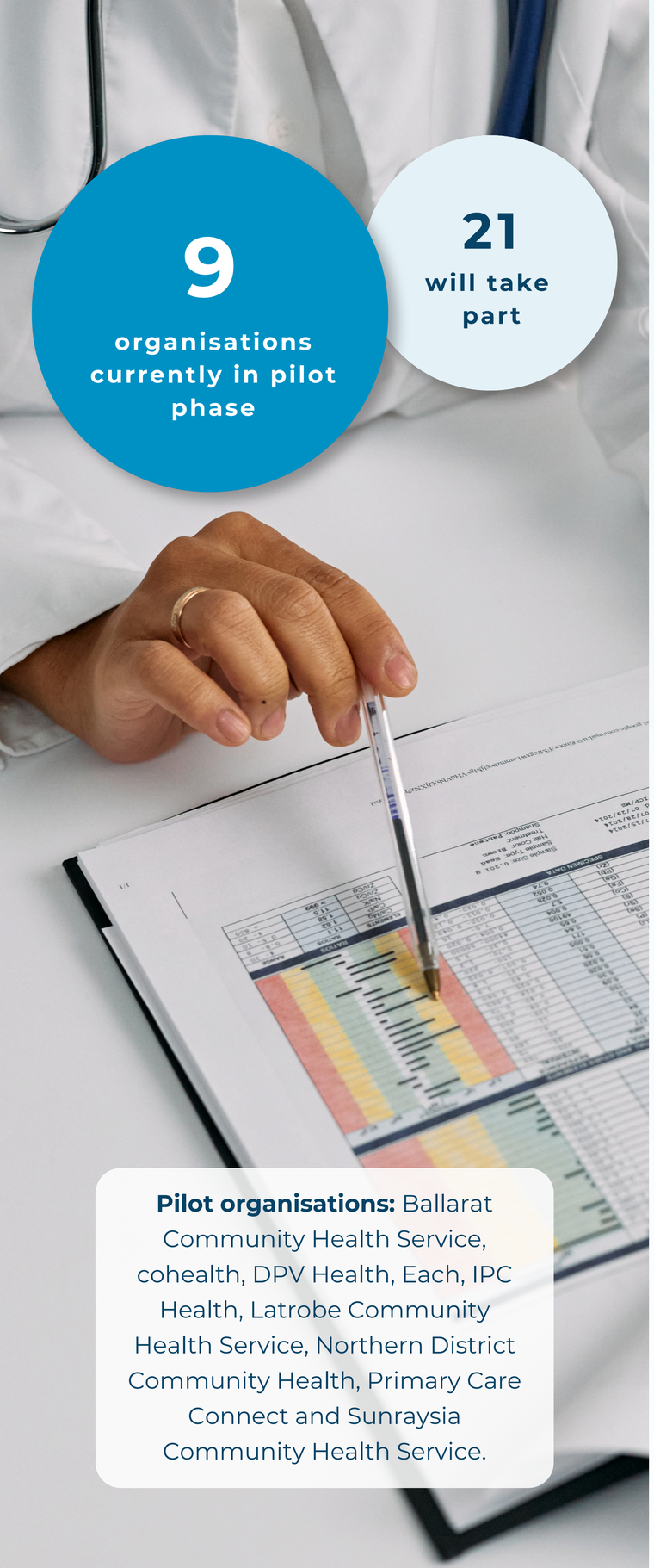
Support is available in person through the Prahran Needle and Syringe Program, and by phone and messaging. Peer workers cover safer injecting, health monitoring, uncertainty about products, engaging with healthcare, and referral to other services. **The program brings four functions together in one model: direct peer support, workforce development, secondary consultations and resource development.**

This creates a live feedback loop between consumers, peer workers and health professionals. Insights from peer conversations inform training and resources, while health professionals can draw on peer expertise through secondary consultations.

BHN
Better Health Network

Building the evidence base

02



Pilot organisations: Ballarat Community Health Service, cohealth, DPV Health, Each, IPC Health, Latrobe Community Health Service, Northern District Community Health, Primary Care Connect and Sunraysia Community Health Service.

SECTOR EXPANSION

Data and evaluation project

The Community Health First Data and Evaluation Project brings together all 21 partner organisations to **measure the difference community health makes to the people and communities we support.** Using a consistent set of short client questionnaires, known as outcome measures, the project is building a shared evidence base on the health and wellbeing of community health clients across Victoria.

The project is supported by a **grant from the Victorian Department of Treasury and Finance's Empowerment Fund.** We're working in **partnership with Monash University's Rehabilitation, Ageing and Independent Living (RAIL) Research Centre**. RAIL is leading the research component under Monash Human Research Ethics Committee governance, and is also conducting research into the broader economic value of community health.

Demand for community health is growing as more Victorians live with chronic conditions and the population ages. Client stories show the impact of our care, but government funding decisions also rely on data that shows impact across whole populations. The sector doesn't yet have a consistent evidence base to show that investing in community health and early intervention reduces costs in hospitals and other acute settings. This project is designed to close that gap.

Nine organisations took part in a pilot phase this year, with the view to start implementing new outcome measures and data capturing processes across the remaining community health organisations in 2027.

Over time, the project will give the sector a shared set of outcome measures that reflect what matters to Victorians. This evidence will help organisations improve their services and show community health's value in early intervention and in easing avoidable pressure on the health system. **A consistent state-wide data set will ensure community health is visible, trusted and sustainably funded into the future.**

EXPANDING ACCESS TO CARE THROUGH CP@CLINIC

Community Paramedics at Clinic (CP@clinic) arrives in Richmond

CP@clinic is a free drop-in service run by community paramedics that originated in Canada and has been adapted for Australia by community health organisations. The clinic runs regularly in locations such as libraries, community centres and social housing common spaces. CP@clinic aims to improve access to care by filling gaps in healthcare services where access is limited, or for people who face barriers to seeking support.

North Richmond Community Health (NRCH) is the **first health service in metropolitan Melbourne to deliver the Community Paramedicine at Clinic (CP@clinic) program**, bringing care directly to the North Richmond community, including residents of the public housing towers. Many people in North Richmond face significant barriers to healthcare. The clinic is free, open to all adults, and requires no referral or Medicare card. Interpreters are available at no cost, and people can drop in or book an appointment, making it accessible to those without a regular GP or with limited English.

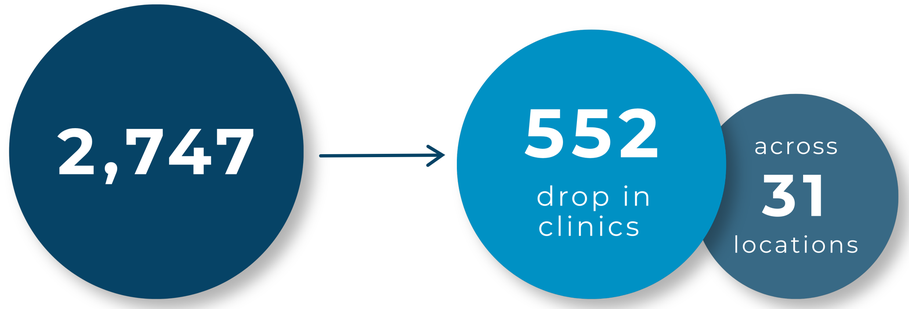
Community Paramedics specialise in non-emergency care. They provide health checks, blood pressure and diabetes management, mental health check-ins, support with personal health goals, and referrals to other services. **By helping people manage chronic conditions early, before they become urgent, the clinic also eases pressure on hospitals and emergency services.** The paramedics work alongside NRCH's GPs and other health professionals as part of the broader care team



north richmond community health
Wulempuri - Kertheba

New research highlights the ongoing success of the CP@clinic model

Across the four CP@clinic sites in Victoria, the program is successfully reaching vulnerable people who struggle to access healthcare and is improving their health, wellbeing and connection to services.



CP@clinics **visits** across Victoria in the last year



Connecting people back to care - 36% of people attending CP@clinic don't have a general practitioner. For many, the paramedic is their main contact with primary care.

Forming connections - 30% of clinic participants are experiencing social isolation.

Addressing long-term health problems - Over 90% of people are presenting with moderate to high diabetes risk which can then be monitored over time.

CP@clinic is an evidence-based program developed by the Department of Family Medicine at McMaster University in Ontario, Canada, and delivered worldwide. In Australia, the program is implemented and evaluated in collaboration with McMaster University and La Trobe University's Violet Vines Marshman Centre for Rural Health Research. In Victoria, the program is delivered by Sunraysia Community Health Services, Primary Care Connect, Grampians Community Health, Gateway Community Health and North Richmond Community Health.

CASE STUDY

Nurse practitioner care for rural communities



Northern District Community Health's Nurse Practitioner-led hubs operate across **five rural sites in three local government areas, improving access to care where GPs are in short supply and distance is a barrier.**

Delivered in partnership with other local services, the hubs have Nurse Practitioners working to their full scope of practice, including prescribing, and providing wraparound support for people living with chronic disease. **They work alongside local GPs, complementing existing care in the community.**

Longer appointments give Nurse Practitioners time to address the more complex issues that can come with living with chronic disease.

Over the past year, the hubs have welcomed Nurse Practitioners specialising in alcohol and other drugs, mental health, primary care, and immunology. In 2026–27, they are also focusing on women's health.

An independent evaluation of the model is underway with Monash University.

CASE STUDY

Healthcare at the school gate



Latrobe Community Health Service places community health nurses in Gippsland primary schools, preschools and childcare settings where there are high levels of vulnerability.

The nurses provide health education, health screening and health management plans. They also work as health navigators, helping children and their families access the services they need so children can attend school, kinder or daycare ready to learn and play.

The program currently operates in **10 primary schools, seven preschools and one childcare setting**. An independent evaluation by Ernst & Young found the program to be **highly effective and good value for money, returning $1.50 for every dollar invested**.

The Nurse in Childcare program is part of a research project with the Colman Education Foundation (Our Place), the Research in Effective Education in Early Childhood (REEaCH) Centre and Goodstart Early Learning.

Wrap around care in action

03

LINKED SERVICES

Many ways in, one place for services

People find community health at every stage of life, and for many different reasons. **1 in 4 people who accessed community health this year received support from more than one service or program**. No matter which door people come through, they are supported and linked to the other services they need.

Below is an example of just some of the ways we linked up with communities this year:

WHO	WAY IN	CONNECTED TO
CHILDREN & FAMILIES	SUPPORTED PLAYGROUPS	PAEDATRIC ALLIED HEALTH PARENTING SUPPORT
YOUNG PEOPLE	SHCOOL HEALTHY EATING PROGRAMS	YOUTH MENTAL HEALTH
ADULTS	GENERAL PRACTICE	ADULT MENTAL HEALTH ALCOHOL & OTHER DRUGS
OLDER PEOPLE	CHRONIC DISEASE MANAGEMENT	DENTAL ALLIED HEALTH SOCIAL SUPPORTS





COMMUNITY FEEDBACK

Close to home, close to community

Client feedback shows how well community health is meeting local needs. This year, people told us their care was safe, accessible and shaped around them, and that having services close to home helps them stay connected to their community.

WHAT CLIENTS TOLD US THIS YEAR

Care is person-centred and effective

Care feels safe, including culturally safe

84%

Said services are accessible

79%

Felt more connected to their community through receiving care

“I find the ageing and support service very helpful for getting out and about, going to appointments, shopping, friendship and social support.”

“We feel really supported and [our clinician] has made a huge positive impact on my daughter’s development. Really glad we have these services in our community.”

“There are a wide range of health services at the same address; there is easy access for many due to its local presence”

CANCER SCREENING

Health screening in community languages



Each works with migrant and refugee communities through bicultural workers, free interpreters and in-language health promotion, including programs that encourage people to take part in cancer screening

One client described how language barriers, not knowing where to find services, and a deep-rooted fear of authority, particularly among elders, had kept people in their community away from screening. They said:

“For our community, navigating healthcare is often overwhelming. Even if we knew the screening existed, fear and communication barriers would keep us away.

“Having access to these supportive programs in our native language changes everything. We can now communicate freely, without fear, supported by staff who are welcoming, smiling and eager to help.

“Without this program, I never would have been checked. I used to think a cancer diagnosis was something we would only discover when it was too late**. Now, I have a chance to catch it and know what’s happening before it’s too late.”**

Each

CONNECTED CARE

Health, housing and legal help in one place

Danielle is raising two school-aged children on her own while managing several chronic health conditions. When she was facing eviction, the strain on her health and on her family’s stability was enormous.

Holstep Health is a short walk from Danielle’s home, and it brings health, social and legal support together under one roof. Because of this, she didn’t have to find her way through a fragmented system on her own.

Her GP, a social worker, the LIFT mental health team and a community lawyer from West Heidelberg Community Legal, all worked together around her and her children. The legal team delayed the eviction and gave Danielle time. Her GP and mental health team supported her through a very difficult period, and emergency relief helped with immediate needs. With that combined support, Danielle secured a new rental.

Today Danielle and her children live in safe, secure housing. That change has made a real difference to the whole family’s health and wellbeing.

“We were able to delay the eviction, and working with her GP at Holstep and the mental health team, support Danielle until she was able to secure a new rental. Now Danielle and her children are living in safe and secure housing, which has made a hugely positive difference to their health and wellbeing.”
Caitlyn, Community Lawyer

“Holstep Health is a short walk from home and I know if I need something I can walk there. **I don’t really know how it would have ended if I hadn’t had support from Holstep Health**. With everything I’ve had going on… I can honestly say I wouldn’t be alive today without their support.”
Danielle



COMMUNITY HEALTH CASE STUDIES

DENTAL

Dental care ten minutes from home

Three years ago, chemotherapy caused Alice to lose so much weight that her dentures no longer fitted. At the time, Alice was travelling 15 kilometres by taxi from her home in Melbourne's northwest to an inner-city dental service. Appointments were hard to get while she recovered from treatment, and the trip was exhausting and expensive.

In 2023, a dental teacher at the service suggested she contact cohealth, which has provided low-cost or free dental care to more than 14,000 people over the past two years. Its Niddrie clinic was just 10 minutes from Alice's home. **"Ten minutes is perfect, it's nothing,"** Alice says.

After her doctor sent a referral, Alice received a call from Helen Carter, who leads the team of Client Service Officers at Niddrie. Helen helped her access the Victorian Denture Scheme (VDS), a government initiative providing low- or no-cost dental care to eligible Victorians.

"It was a godsend," Alice says, **"because I didn't know that things (like the VDS) even existed.** Helen was a lifesaver. If it wasn't for her, I would be in a deep hole. I would have cracked it. She gave me the peace of mind that I'm going to be okay.

And now, I have beautiful dentures."



cohealth
care for all

REFUGEE & MIGRANT HEALTH



Cancer care that bridges the gap

Greater Bendigo is one of Victoria's top regional settlement areas for humanitarian refugee arrivals. Bendigo Community Health Services employs bicultural staff with lived experience to help local refugee and migrant communities build connections, health literacy and wellbeing.

Bendigo Community Health Services' Multicultural Health Equity team launched the Cancer Support for People of Refugee Background program three years ago, after a trend of late-stage diagnoses was identified in the Karen community. Delivered in partnership with Loddon Mallee Integrated Cancer Service and in collaboration with Bendigo Regional Cancer Centre, the program makes cancer prevention, screening and treatment more accessible. A dedicated bicultural Health Navigator advocates for people diagnosed with cancer as they navigate health services.

In the past year, the **program delivered 58 cancer prevention sessions to 515 participants**. New in-language treatment sessions, co-designed with an oncology nurse, are adapted to community literacy needs and help dispel common myths about cancer treatment. The program has received almost $2.5 million in state government funding to expand.

One client currently receiving treatment said, "this program is like a bridge to cancer care because the navigator always guides us, gives us encouragement and speaks on our behalf to clarify things that confuse us. **Because of this I feel more confident accessing cancer care, and I feel safe and comfortable every time we visit the Cancer Centre... this program truly becomes your strength."**

Bendigo Community Health Services

COMMUNITY HEALTH CASE STUDIES

WRAP AROUND CARE

Breathing easy with linked-up supports

When Judith's GP referred her to Primary Care Connect (PCC) for ongoing breathing difficulties, she joined its **Pulmonary Rehabilitation Program**.

Judith completed the program and found the exercises and health information particularly helpful for her shortness of breath, mobility and arthritis.

During her assessment and throughout the program, her clinician identified that she would also benefit from seeing a dietitian, and referred her to PCC's in-house dietitian.

Working with the dietitian, Judith achieved her diet-related goals, which further improved the health concerns that first brought her to PCC.

Having these services under one roof meant Judith could get the extra support she needed without starting again with a new provider.



PRIMARY CARE CONNECT



Find out more at

communityhealthfirst.org.au

COMMUNITY HEALTH FIRST

Community Health First acknowledges the traditional custodians of the lands on which we live and work, and we pay our respects to Elders past and present.